



Office of Public Instruction
Linda McCulloch, Superintendent
PO Box 202501
Helena, MT 59620-2501

Evaluation Report

STUDENT INFORMATION

Student Name	Initials	Birthdate	Age	Gender M F	Grade	Today's Date
District/School	Initial Referral Date				Initial Evaluation <input type="checkbox"/>	
	Next Comprehensive Reevaluation Due				Reevaluation <input type="checkbox"/>	
Parent(s)' Name	Parent(s)' Address				Home Phone	
	E-mail				Work Phone/Cell Phone	

EVALUATIONS AND INFORMATION PROVIDED BY THE PARENT(S) AND/OR STUDENT

Parent Comments*: _____

Student Comments: _____

Implications for Educational Planning: _____

ASSESSMENT AREAS

Assessment results, including implications for educational planning, may be summarized or attached as written reports.

Summarized	Attached	Summarized	Attached
<input type="checkbox"/>	<input type="checkbox"/> Academic Achievement	<input type="checkbox"/>	<input type="checkbox"/> Observations*
<input type="checkbox"/>	<input type="checkbox"/> Assistive Technology/Services	<input type="checkbox"/>	<input type="checkbox"/> Physical
<input type="checkbox"/>	<input type="checkbox"/> Behavioral	<input type="checkbox"/>	<input type="checkbox"/> Psychological
<input type="checkbox"/>	<input type="checkbox"/> Classroom-Based Assessment*	<input type="checkbox"/>	<input type="checkbox"/> Social/Emotional
<input type="checkbox"/>	<input type="checkbox"/> Communication	<input type="checkbox"/>	<input type="checkbox"/> Transition
<input type="checkbox"/>	<input type="checkbox"/> Developmental	<input type="checkbox"/>	<input type="checkbox"/> Other: _____
<input type="checkbox"/>	<input type="checkbox"/> Functional Behavior Assessment		

* Required

Student Name: _____ Evaluation Report Date: _____

ASSESSMENT SUMMARIES

Assessment Area: _____ Evaluator(s): _____ Date of Eval/Observ: _____

Results: _____

Implications for Educational Planning: _____

Assessment Area: _____ Evaluator(s): _____ Date of Eval/Observ: _____

Results: _____

Implications for Educational Planning: _____

Assessment Area: _____ Evaluator(s): _____ Date of Eval/Observ: _____

Results: _____

Implications for Educational Planning: _____

Student Name: _____ Evaluation Report Date: _____

ASSESSMENT SUMMARIES

Assessment Area: _____ Evaluator(s): _____ Date of Eval/Observ: _____

Results: _____

Implications for Educational Planning: _____

Assessment Area: _____ Evaluator(s): _____ Date of Eval/Observ: _____

Results: _____

Implications for Educational Planning: _____

Assessment Area: _____ Evaluator(s): _____ Date of Eval/Observ: _____

Results: _____

Implications for Educational Planning: _____

Student Name: _____ Evaluation Report Date: _____

ELIGIBILITY DETERMINATION

Student **IS** eligible for special education and related services under the Individuals with Disabilities Education Act. Basis for making the determination that the student has a disability and needs special education and related services:

Disability criteria: _____

☐ Criteria Checklist Attached

Why does the student need special education and related services? _____

Disability Categories (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Deafness | <input type="checkbox"/> Other Health Impairment ² |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Emotional Disturbance | <input type="checkbox"/> Specific Learning Disability |
| <input type="checkbox"/> Cognitive Delay | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Speech Language Impairment |
| <input type="checkbox"/> Deaf-Blindness | <input type="checkbox"/> Orthopedic Impairment ¹ | <input type="checkbox"/> Traumatic Brain Injury |
| | | <input type="checkbox"/> Visual Impairment |

¹ Medical report required (diagnosis of orthopedic impairment by a qualified medical practitioner)

² Medical report required (medical diagnosis of chronic or acute health problem)

Recommendations for consideration by the IEP team:

Special Education Services

- | | | |
|---|--|---|
| <input type="checkbox"/> Adapted Physical Education | <input type="checkbox"/> Math | <input type="checkbox"/> Speech/Language |
| <input type="checkbox"/> Assistive Technology | <input type="checkbox"/> Reading | <input type="checkbox"/> Transition |
| <input type="checkbox"/> Braille Instruction | <input type="checkbox"/> Self-Help/Independence | <input type="checkbox"/> Travel Training |
| <input type="checkbox"/> Career/Vocational | <input type="checkbox"/> Sensory-Motor | <input type="checkbox"/> Written Expression |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Social/Emotional/Behavioral | |

Related Services

- | | | |
|--|---|---|
| <input type="checkbox"/> Assistive Technology | <input type="checkbox"/> Orientation and Mobility | <input type="checkbox"/> School Health/Nurse Services |
| <input type="checkbox"/> Audiology | <input type="checkbox"/> Parent Counseling and Training | <input type="checkbox"/> Social Work in Schools |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Speech/Language |
| <input type="checkbox"/> Early Identification/Assessment | <input type="checkbox"/> Psychological | <input type="checkbox"/> Therapeutic Recreation |
| <input type="checkbox"/> Medical (diagnostic) | <input type="checkbox"/> Recreation | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Rehabilitation Counseling | <input type="checkbox"/> Other: _____ |

DOCUMENTATION—if not eligible

Student **IS NOT** eligible for special education and related services under the Individuals with Disabilities Education Act for the following reason(s):

- | | |
|--|---|
| <input type="checkbox"/> Does not meet disability criteria | <input type="checkbox"/> Lack of instruction in reading or math |
| <input type="checkbox"/> Does not demonstrate need for special education | <input type="checkbox"/> Limited English proficiency |

Discussion: _____

Recommendation for accommodation or referral for other services as appropriate: _____

Student Name: _____ **Evaluation Report Date:** _____

The following persons, as indicated by their signatures, have participated in the development of this Evaluation Report document. The public agency shall give the parent a copy of the child's Evaluation Report document at no cost to the parent.

_____ Parent	_____ Date	_____ Parent	_____ Date
_____ Student	_____ Date	_____ Speech/Language Pathologist	_____ Date
_____ Administrator or Designee	_____ Date	_____ Signature/Position	_____ Date
_____ Regular Education Teacher	_____ Date	_____ Signature/Position	_____ Date
_____ Special Education Teacher	_____ Date	_____ Signature/Position	_____ Date
_____ School Psychologist	_____ Date	_____ Signature/Position	_____ Date

Each participant of the Evaluation Team shall be provided an opportunity to submit a separate statement of conclusions if the report does not reflect the conclusions of the participant. ☐ Dissenting report will be attached.

Person(s) submitting a separate statement of conclusions: _____

Reasons: _____

Evaluation Report Meeting Notes

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